Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of ___North Carolina_____ enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_X_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

_X_ i. fee for service;
____ii. capitation;
_X_ iii. a case management fee;
____iv. a bonus/incentive payment;
____ v. a supplemental payment, or
_X_ vi. other. (Please provide a description below).

Carolina ACCESS (CA), implemented in 1991, is the Division of Medical Assistance (DMA) primary care case management (PCCM) program in which the primary care provider (PCP) coordinates patient care and acts as a gatekeeper. Providers are reimbursed fee for service and the PCPs receive a management fee for each recipient. The PCPs receive a per member per month management fee for each recipient.

Citation	Condition or Requirement

Community Care of North Carolina (CCNC) (formerly known as ACCESS II), launched in July of 1998, is an enhanced primary care case management program in which Carolina ACCESS PCPs have joined together to form distinct networks headed by an administrative entity. The networks have developed care management and disease management strategies targeted to their respective populations. The PCPs receive a management fee per member per month and all providers are paid on a fee-for-service basis. The administrative entity receives an additional management fee per member per month for the enhanced services.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

   If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

   ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

   ____ii. Incentives will be based upon specific activities and targets.

   ____iii. Incentives will be based upon a fixed period of time.

   ____iv. Incentives will not be renewed automatically.

   ____v. Incentives will be made available to both public and private PCCMs.

   ____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

   __X__vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation	Condition or Requirement

Recipients enrolled with the PCCM managed care option have public input through the Division's toll free hotline number that is manned from eight to five, Monday through Friday by Managed Care staff. Voice mail is available after hours for the recipient; the appropriate managed care staff person will return their call as soon as possible.

The local CCNC networks also work with the patients on self management strategies for many of the chronic diseases that are managed through the program. This provides an opportunity for the patient to have involvement in the care management plan being proposed.

Patients are also able to submit a concern about the program through a written complaint process.

The NC Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Recipients have an opportunity to serve on this Committee.

1932(a)(1)(A)

5. The state plan program will_X_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. __X__ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. __X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. ____The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

- Work First for Family Assistance (formerly AFDC)
- Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
- Medicaid for the Blind and Disabled (MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD)
- Qualified Alien

Children under age 19 identified as Children with Special Health Care Needs, dual eligibles, and Indians who are members of a Federally recognized tribes are exempt from mandatory enrollment.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Citation	Condition or Requirement
	Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. __X__ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)* The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. __X__ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. __X__ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. __X__ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. __X__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. __X__ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.

Citation	Condition or Requirement

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

The State defines these children in terms of special health care needs and program participation in Development Evaluation Center (DEC) and Child Special Health Services (CSHS).

The Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X_iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X_i. yes
___ii. no

1932(a)(2)
CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt 42 from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

The State identifies this group by Medicaid eligibility category of assistance.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

The State does not enroll this population in the managed care programs.

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; The State identifies this group by the Medicaid eligibility category of assistance. iv. Children under 19 years of age who are receiving foster care or adoption assistance. The State identifies this group by the Medicaid eligibility category of assistance.
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* The Division of Medical Assistance has instituted a questionnaire, with 5 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN. The State has an internal exemption process that approves or denies Medicaid recipients' exemption requests from participation in our PCCM option for medical reasons. The medical exemption requests are reviewed and approved by the Managed Care staff. Recipient who have ESRD, terminal illness or require hospice services are automatically made exempt by the State. An exemption is deemed necessary when it is determined that in order to maintain continuity of care it would be necessary to medically exempt the recipient from the PCCM health care option. The recipient and the county DSS office are notified in writing of the approval or denial of an exemption request.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. These recipients are identified by Medicaid eligibility category of assistance. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian

Citation	Condition or Requirement

Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories. When a Native American applies for Medicaid, he is automatically exempted from enrollment into managed care based on his membership in a federally recognized tribe and not on his eligibility group.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

There are no other exempt populations (not previously mentioned).

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

Community Alternative Program (CAP) Enrollees are allowed to voluntarily enroll in Carolina ACCESS and CCNC (formerly known as ACCESS II).

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Citation | Condition or Requirement

The caseworkers in each local county Department of Social Services (DSS) are responsible for auto-assignments on an individual basis when recipients have not selected a provider.

The State assures that default enrollment will be based first upon maintaining existing provider-patient relationships. Most beneficiaries receive education as to their managed care options verbally through staff at their respective county DSS. Inquiries are made for potential default enrollment as to current provider-patient relationships when recipients do not select a PCP at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) recipients, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of their PCP selection.

Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.

The county DSS staff reviews the SSI exempt report and auto-assign all recipients who have been on the report for 30 days or more and assigns them to a PCP. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook. Paid claims history is searched to determine if the recipient had any visits to specialists. If the recipient's data show more than one specialist with paid claims, the specialist with the highest frequency of visits is selected as the specialist of choice.

Paid claims history is searched to determine if the recipient had any hospital visits. If there is a hospital claim and if the PCCM has the hospital in their network, it is allowed to remain as a possible assignment.

If no claims were paid to PCPs or specialists, and only hospital claims existed, then the PCCM with that hospital in their network is allowed to remain as possible assignment.

If no paid claims history exists, the recipient is assigned according to the algorithm assignment used for the general population.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and

Citation	Condition or Requirement

disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

If it is not possible to obtain provider-patient history, beneficiaries are assigned to providers based upon equitable distribution among participating PCPs available in the recipient's county of residence.

Caseworkers are told to look at the provider restrictions, e.g. patients 21 and under or established patients only, listed in the State Eligibility Information System (EIS), and geographical proximity to the provider before auto assigning a recipient.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

   i. The state will____/will not_X_ use a lock-in for managed care managed care.

   ii. The time frame for recipients to choose a health plan before being auto-assigned will be___90 days_____.

   iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.

The county DSS staff reviews the SSI exempt report and auto-assign all recipients who have been on the report for 30 days or more and assigns them to a PCP. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook.

   iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Caseworkers at the local DSS are trained to make every effort to support a Provider patient relationship with the auto-assignment. If this is not present, then caseworkers are instructed to equally distribute patients to all providers who are accepting new patients on a case by case basis.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker.)*

MMIS produces a monthly provider availability report that is reviewed by the regional managed care consultant to determine if a provider is reaching his or her enrollment limit.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ___ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   ___This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

_X_ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_X_ use lock-in for managed care.

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following Carolina ACCESS and ACCESS II exempt services do not require PCPs authorization:

Ambulance
Anesthesiology
At Risk Case Management
CAP Services
Certified Nurse Anesthetist
Child Care Coordination Services
Dental
Developmental Evaluation Centers
Maternity Care Coordination
Diagnosis and treatment of emergency conditions
Eye exam for glasses
Family Planning
Head Start Programs
Health Department Services
Hearing Aids
Hospice
Laboratory Services
Mental Health

Citation | Condition or Requirement

Optical Supplies/Visual Aids
Pharmacy
X-Ray Services not done in the Hospital
Pathology Services
School Services

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not_X_ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.